(For LCC Use)
Client Name (Last, First, M.I.): _____ Chart #: _____
Enrollment Site: _____ Enrollment/Re-Enrollment Date: _____/_____/_____

(vers. 10.2008)

Idaho Women's Health Check Enrollment Form

IDAHO DEPARTMENT OF HEALTH & WELFARE

Client Eligibility *(Please verify prior to enrollment and screening. For Office Use Only)*

1. U.S. Citizen? ☐ Yes ☐ No
   If No - Alien ID? ☐ Yes ☐ No
2. Total number living in household (including yourself) _____
   Is a spouse currently living with you? ☐ Yes ☐ No
   Number of children under age 19 _____
3. Do you currently have health insurance? ☐ Yes ☐ No
   Does it cover mammograms and Pap tests? ☐ Yes ☐ No
   Does the amount of your deductible prevent you from getting a mammogram or Pap test? ☐ Yes ☐ No
   Type of health insurance:
   - ☐ Private
     Name of Company: _____
   - ☐ Medicaid
   - ☐ Medicare—Part A Only

4. Total household income (gross) before taxes:
   $_____yearly or $_____monthly
5. Age: ☐ 50-64 (eligible for breast and cervical screening)
   ☐ 40-49 (eligible for cervical screening)
   ☐ 30+ * (limited enrollment—client symptomatic for cancer)
   **limited enrollment authorization form attached*

This client meets all enrollment requirements.
____ Citizen/eligible alien
(alien must live in United States at least 5 continuous years)
____ No insurance coverage
____ Income *(use current table)*
____ Age
Eligibility verified by: _____

1. Client Information (*required*)

Last Name:_____ **First:** _____ **Middle:** _____
Maiden Name (*if applicable*): _____ **Date of Birth:** _____/_____/_____
U.S. Citizen? ☐ **Yes** ☐ **No** **Place of Birth (State):** _____
Social Security #: _____-_____-_____ *OR* **Alien ID #:** _____ **Issue Date:** _____/_____ Mo./ Year
Home Mailing Address: _____
City: _____ **County:** _____ **State:** _____ **Zip:** _____
Home/Cell Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

2. Ethnicity and Race (*all answers required*)

Ethnicity: *(check one)*
- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Unknown

What race do you consider yourself? *(check all that apply)*
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Pacific Islander or Native Hawaiian
- ☐ American Indian or Alaska Native
- ☐ Unknown

What language do you prefer for medical information? *(check one)*
- ☐ English
- ☐ Spanish

3. Emergency Contact

Someone we may contact in case we cannot reach you:
First Name: _____
Last Name: _____
Phone: (_____) _____-_____

4. How did you hear about this program? *(check all that apply)*

- ☐ Health Care Provider
- ☐ Community Event/Health Fair
- ☐ Friend/Relative
- ☐ Health Department
- ☐ Radio
- ☐ Television
- ☐ Other _____
- ☐ American Cancer Society
- ☐ Church Bulletin
- ☐ Foodbank
- ☐ Newspaper
- ☐ Reminder Notice
- ☐ Web

Please check all that apply. Knowingly providing false information may result in criminal, civil or administrative action.

- ☐ The information I have provided on this form is correct.
- ☐ I wish to start/continue receiving services through Idaho's Women's Health Check.
- ☐ I am a U.S. Citizen. *(*Original birth certificate or documentation of citizenship will be required should you need treatment.)*
  OR ☐ I have an Alien ID and have lived in the United States for at least 5 years. (Alien ID card will be required should you need treatment.)

Client Signature: _____ **Date:**_____/_____/_____